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| **Name of applicant** | | |  | | | | | | **Date**: | | | |
| **Relevant qualification(s) and date(s) completed** | | |  | | | | | | | | | |
| **Current registration or professional body (HCPC, NMC, GMC, SVT, IPEM, other)** | | |  | | | | | | | | | |
| **Name & address of the ultrasound clinical placement(s)** | | | | | | | | | | | | |
| **Type of institution/s**: e.g. DGH, University, Teaching, Private, Other (please state) | | | | | | | | | | | | |
| **Clinical Areas To Be Studied (Indicate those which are appropriate “X” )** | | | | | | | | | | | | |
| General Medical |  | 3rd trimester only | | |  | | MSK (upper limb only) |  | | Lower Limb Arterial | |  |
| Obstetrics (all trimesters) |  | EPAU (only) | | |  | | MSK (lower limb only) |  | | Lower Limb Venous Insufficiency | |  |
| Gynaecology |  | Baby hips | | |  | | MSK (groin, lumps and bumps only) |  | | Haemodialysis Access | |  |
| 1st trimester only |  | Carotid only | | |  | | Testes |  | | Head and Neck | |  |
| 2nd trimester only |  | Lower Limb DVT only | | |  | | Thyroid |  | |  | |  |
| Other | | | | | | | | | | | | |
| **Please indicate the caseload relevant to the subspecialty studied (approximate number of cases per month)** | | | | | | | | | | | | |
| **Staff Involved in Teaching** | | | | | | | | | | | | |
| Role (e.g. sonographer, radiologists, obstetrician, physiotherapist, nurse, midwife) | | | | | | Years of relevant ultrasound experience | | | | | | |
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| **Ultrasound Equipment. Please indicate the number of ultrasound machines and date of commissioning.** | | | | | | | | | | | | |
| 1. | | | | 3. | | | | | | | | |
| 2. | | | | 4. | | | | | | | | |
| **Other Learning Resources (library, MDT meetings, CPD, local and national meeting, ….)** | | | | | | | | | | | | |
| **Has your department previously been involved in training ultrasound practitioners?** | | | | | | | | | | | YES / NO | |
| If yes, please specify training organisation, e.g. in-house or name of external educational institution. | | | | | | | | | | | | |
| **Are you currently training any students within your ultrasound department?** | | | | | | | | | | | YES / NO | |
| If yes, please indicate how many students | | | | | | | | | | | | |
| **Will your department be able to provide the UWE student with a minimum of 15 hrs a week supervised “hands on” clinical based training as required by UWE ultrasound professional practice module?** | | | | | | | | | | | YES / NO | |
| **Appraisers:** Please supply the name of the member(s) of staff willing to act as your supervisor and assessor. Please provide details of their ultrasound experience and qualifications: | | | | | | | | | | | | |
| Principal Appraiser  Name:  Qualifications:  e-mail:  Contact number: | | | | | | Principal Appraiser’s supporting statement  *I agree to act as a supervisor and assessor for the student and to attend the UWE appraisers’ training day.*  Signature: | | | | | | |
| 2nd Appraiser  Name:  Qualifications:  e-mail:  Contact number: | | | | | | | | | | | | |
| **Managerial Support:** This section below is to be completed by the departmental manager.  I understand that in order for the student to be accepted on this programme protected supervised scanning must be guaranteed. During this time the student will gain a minimum of 2 days “hands on” ultrasound experience and receive appropriate tuition and supervision from experienced sonographers. | | | | | | | | | | | | |
| **Name:**  **Position:**  **Signature:** | | | | | | | **e-mail:**  **Contact Number:**  **Date:** | | | | | |
| Please include any other information you think is relevant for the University to determine the suitability of your clinical placement and supervisor for your training and assessment: | | | | | | | | | | | | |
| **Student Declaration**  I certify that the above information is true and complete to the best of my knowledge.  Student Signature: | | | | | | | | | | | | |
| **Once completed please upload the document to your online application** | | | | | | | | | | | | |